



ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Delta Dental of California
P.O. Box 429086
San Francisco, CA 94142-9086
www.deltadentalins.com

VERY IMPORTANT - Please Print Legibly

Enrollee/Change Information

- New Enrollment
 Marital Status Change
 Terminate Enrollee Coverage
 SSN/Enrollee ID Number Correction or previous ID under which benefits are received
- Add/Delete Dependent
 Address Change
 Other _____

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
/ /		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married
First Name	Last Name	Middle Initial		
Mailing Address (Street)	City	State	Zip Code	
E-mail Address (internal use only)	Phone Number () -	Phone Type	Cell <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/>	
Name of Other Dental Carrier	Policy Holder Name (first/last)	Date of Birth	/ /	
Effective Date of Other Policy / /	Policy Holder Street Address	City	State	Zip Code

FOR GROUP USE ONLY

Group No.	Division	State
Effective Date / /	Hire Date / /	
Name of Employer		
Location	Pay Code	Benefit Package

Enrollee Classification

- Full-Time
 Hourly
 Certified
- Part-Time
 Salaried
 Classified
- Retired
 Member/Other _____

COBRA (if applicable)

- Termination
 Reduction in Hours
 Divorce/Legal Separation*
 Widowed/Surviving Dependent*
 Dependent Child No Longer Eligible*

Indicate qualifying date: / /

*If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided.**

Dependent Information

Relationship	Dependent First Name (Last only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled**	Name of School (coverage student)**
Spouse/Partner		<input type="checkbox"/> <input type="checkbox"/>	/ /	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	/ /	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	/ /	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	/ /	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Dependent		<input type="checkbox"/> <input type="checkbox"/>	/ /	/ /	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. **Additional documentation will be required for disabled and student status.

I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

I decline coverage at this time.

Signature of Enrollee _____

Date / /